DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Inpatient Prospective Payment System (IPPS) Hospital Extensions per the Medicare Access and CHIP Reauthorization Act of 2015

Note: This article was revised on June 9, 2015, to reflect the revised CR9197 issued on June 5. In the article, the CR release date, transmittal number, and the Web address for accessing CR9197 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

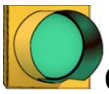
STOP – Impact to You

This article is based on Change Request (CR) 9197 which provides information and implementation instructions for Sections 204 and 205 of the Medicare Access and CHIP Reauthorization Act of 2015.

CAUTION – What You Need to Know

On April 16, 2015, the president signed into law the Medicare Access and CHIP Reauthorization Act of 2015. The new law includes the extension of certain provisions of the Affordable Care Act. Specifically, Section 204 and Section 205 (see below) of the

Medicare Inpatient Prospective Payment System (IPPS) fee-for-service policies have been extended through September 30, 2017.



GO – What You Need to Do

Make sure that your billing staffs are aware of these changes.

Background

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (see **https://www.congress.gov/114/bills/hr2/BILLS-114hr2ih.pdf**). The following Medicare Inpatient Prospective Payment System (IPPS) fee-for-service policies have been extended through September 30, 2017.

Section 204 – Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals

The Affordable Care Act (see **http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf**) provided for temporary changes to the low-volume hospital adjustment for Fiscal Years (FYs) 2011 and 2012. To qualify, the hospital must have less than 1,600 Medicare discharges and be located more than 15 miles from the nearest IPPS hospital.

Section 205 - Extension of the Medicare-Dependent Hospital (MDH) Program - The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges.

The Medicare Access and CHIP Reauthorization Act of 2015 provides for an extension of the temporary changes to the low-volume hospital adjustment and of the MDH program for discharges occurring on or after April 1, 2015, through FY 2017 (that is, for discharges occurring on or before September 30, 2017). Prior legislation extended these adjustments through March 31, 2015.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2015

The Centers for Medicare & Medicaid Services (CMS) implemented the changes to the low-volume hospital adjustment provided by the Affordable Care Act as extended by subsequent legislation in the regulations at **42 CFR §412.101**. For additional information, refer to the FY 2011 IPPS/LTCH PPS final rule, **75 FR 50238 through 50275**, the FY 2014 IPPS/LTCH PPS final rule, **78 FR 50611 through 50613,**) and the FY 2015 IPPS/LTCH PPS final rule, **79 FR 50428.**

To implement the extension of the temporary change in the low-volume hospital payment policy [as provided for bySection 204 of the Medicare Access and CHIP Reauthorization Act of 2015, consistent with the existing regulations at 42 CFR §412.101(b)(2)(ii)], the same discharge

data used for the low-volume adjustment for discharges occurring during the first half of FY 2015 will continue to be used for discharges occurring during the last half of FY 2015, as these data were the most recent available data at the time of the development of the FY 2015 payment rates. Specifically, for FY 2015 discharges occurring on or after April 1, 2015, through September 30, 2015, the low-volume hospital qualifying criteria and payment adjustment (percentage increase) is determined using FY 2013 Medicare discharge data from the March 2014 update of the MedPAR files. This discharge data can be found in Table 14 of the Addendum of the FY 2015 IPPS final rule (**CMS-1607-F**). In order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume adjustment for FY 2015 is the data from the March 2014 update of the FY 2013 MedPAR file. CMS notes, Table 14 provides a list of IPPS hospitals with fewer than 1,600 Medicare discharges, and is not a listing of the hospitals that qualify for the low-volume hospital adjustment for FY 2015 since it does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital must also be located more than 15 road miles from any other IPPS hospital). In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2015 discharges, a hospital must meet both the discharge and mileage criteria.

MACs will notify hospitals that had a FY 2015 low-volume hospital status determination on March 31, 2015, that their status has been reinstated for the remainder of FY 2015 provided that the hospital continues to meet the mileage criterion (that is, it continues to be located more than 15 road miles from any other IPPS hospital). In other words, the hospital will continue to have low-volume hospital status for the last half of FY 2015 provided there have not been any changes in the hospital's proximity to another IPPS hospital subsequent to the hospital's notification to its MAC that it met the low-volume hospital criteria for the first half of FY 2015. For requests for low-volume hospital status for FY 2015 received after April 1, 2015, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that will be applicable prospectively within 30 days of the date of the MAC's low-volume hospital status determination, consistent with the historical policy of CMS.

In order to implement this policy for FY 2015 discharges occurring on or after April 1, 2015, the Pricer will continue to include a table containing the provider number and discharge count determined from the March 2014 update of the FY 2013 MedPAR file. The discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units. Consistent with prior practice, the table in Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, it is located more than 15 road miles from the nearest IPPS hospital).

The applicable low-volume hospital adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, Indirect Medical Education (IME) and outliers. For Sole-

Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs), the applicable low-volume percentage increase is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Reinstatement of Medicare Dependent Hospital (MDH) Status

Under Section 3124 of the Affordable Care Act, the MDH program authorized by the Social Security Act (section 1886(d)(5)(G) was set to expire at the end of FY 2012. These amendments were extended through March 31, 2015 by subsequent legislation. Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 extends the MDH program through September 30, 2017. CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in the regulations at **42 CFR §412.108.** For additional information, refer to the FY 2011 IPPS/LTCH PPS final rule **75 FR 50287**, the FY 2013 IPPS/LTCH PPS notice (78 FR 14691 through 14692), the FY 2014 IPPS/LTCH PPS final rule **78 FR 50647 through 50649**, the FY 2014 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final rule with Comment (IFC) (March 18, **2014; 79 FR 15025 through 15028)** and the FY 2015 IPPS/LTCH PPS final rule, **79 FR 50429.**

Consistent with the implementation of previous CMS extensions of the MDH program, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective April 1, 2015, with no need to reapply for MDH classification. However, there are the following two exceptions:

a. MDHs that were classified as Sole-Community Hospitals (SCHs) on or after April 1, 2015

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by March 1, 2015 (that is, 30 days prior to the expiration of the MDH program), to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of April 1, 2015. Additionally, some hospitals that had MDH status as of the April 1, 2015, expiration of the MDH program may have missed the March 1, 2015, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than April 1, 2015.

b. MDHs that requested a cancellation of their rural classification under 42 CFR §412.103(b)

In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR §412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to April 1, 2015. All other former MDHs will be automatically reinstated as MDHs effective April 1, 2015. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR §412.108(a). You can review **42 CFR §412.108**. Specifically, the regulations at 42 CFR §412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its MAC to be considered for MDH status (42 CFR §412.108(b)(2)).
2. The MAC make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (42 CFR §412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the MAC's written notification to the hospital (42 CFR§412.108(b)(4)).

Cancellation of MDH status

As required by the regulations at 42 CFR §412.108(b)(5), MACs must "**evaluate on an ongoing basis**" whether or not a hospital continues to qualify for MDH status.

Therefore, as required by the regulations at 42 CFR §412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 42 CFR §412.108(a), and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to April 1, 2015 (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

The following table outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario. The examples immediately follow the table.

If the provider was classified as an MDH as of the March 31, 2015 expiration of the MDH provision and the provider:	Then	Corresponding Example #
Did not reclassify as an SCH since April 1, 2015 and continues to be classified as a rural provider	MDH status will be automatically reinstated to April 1, 2015.	1
Reclassified as an SCH immediately following the expiration of the MDH provision with SCH status effective April 1, 2015	The provider's MDH status will not be automatically reinstated and the provider will have to reapply for MDH classification (§412.108(b)).	2
Reclassified as an SCH, but the effective date of SCH status was a date after April 1, 2015	The provider's MDH status will be reinstated, effective April 1, 2015 for the portion of time during which it was not classified as an SCH. The provider's MDH status will be cancelled effective with the effective date of its SCH status. The provider will have to reapply for MDH classification (§412.108(b)).	3
Cancelled its rural classification under §412.103 effective April 1, 2015	The provider's MDH status will not be automatically reinstated and the provider will have to reapply for rural classification (§412.103(b)) and then reapply for MDH classification (§412.108(b)).	4
Cancelled its rural classification under §412.103, but the effective date of the rural status cancellation was a date after April 1, 2015	The provider's MDH status will be reinstated for the portion of time during which it was classified as rural. The provider's MDH status will then be cancelled effective with the date that its rural classification cancellation became effective. The provider will have to reapply for rural classification (§412.103(b)) and then reapply for MDH classification (§412.108(b)).	5

If the provider was classified as an MDH as of the March 31, 2015 expiration of the MDH provision and the provider:	Then	Corresponding Example #
Did not reclassify as an SCH and continues to be classified as a rural provider but has a Medicare utilization rate < 60% in the three most recently settled cost reports	MDH status will be automatically reinstated to April 1, 2015. The MAC will then notify the provider that it no longer meets MDH criteria and will cancel MDH status in accordance with the regulations at §412.108(b)(6).	6

Examples:

Example 1: Hospital A was classified as an MDH prior to the March 31, 2015, expiration of the MDH program. Hospital A retained its rural classification and did not reclassify as an SCH. Hospital A's MDH status will be automatically reinstated to April 1, 2015.

Example 2: Hospital B was classified as an MDH prior to the March 31, 2015, expiration of the MDH program. In accordance with the regulations at §412.92(b)(2)(v) and in anticipation of the expiration of the MDH program, Hospital B applied for classification as an SCH by March 1, 2015, and was approved for SCH status effective on April 1, 2015. Hospital B's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital B must cancel its SCH status, in accordance with §412.92(b)(4), and reapply for MDH status in accordance with the regulations at §412.108(b).

Example 3: Hospital C was classified as an MDH, prior to the March 31, 2015, expiration of the MDH program. Hospital C missed the application deadline of March 1, 2015, for reclassification as an SCH under the regulations at §412.92(b)(2)(v) and was not eligible for its SCH status to be effective as of April 1, 2015. Hospitals C's MAC approved its classification request for SCH status effective May 16, 2015. Hospital C's MDH status will be reinstated but only for the portion of time in which they met the criteria for MDH status. Hospital C's MDH status will be reinstated effective April 1, 2014, through May 15, 2015, and will be cancelled effective May 16, 2015. In order to reclassify as an MDH, Hospital C must cancel its SCH status, in accordance with §412.92(b)(4), and then reapply for MDH status in accordance with the regulations at §412.108(b).

Example 4: Hospital D was classified as an MDH prior to the March 31, 2015 expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital D requested that its rural classification be cancelled in accordance with the regulations at §412.103(g). Hospital D's rural classification was cancelled effective April 1, 2015. Hospital D's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital D must

request to be reclassified as rural under §412.103(b) and must reapply for MDH status under §412.108(b).

Example 5: Hospital E was classified as an MDH prior to the March 31, 2015, expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital E requested that its rural classification be cancelled in accordance with the regulations at §412.103(g). Hospital E's rural classification was cancelled effective July 1, 2015. Hospital E's MDH status will be reinstated but only for the portion of time in which they met the criteria for MDH status. Since Hospital E cancelled its rural status and became urban effective July 1, 2015, MDH status will only be reinstated effective April 1, 2015, through June 30, 2015, and will be cancelled effective July 1, 2015. In order to reclassify as an MDH, Hospital E must request to be reclassified as rural under §412.103(b) and must reapply for MDH status under §412.108(b).

Example 6: Hospital F was classified as an MDH prior to the March 31, 2015, expiration of the MDH provision. The hospital's MAC found that Hospital F had a Medicare utilization rate of less than 60 percent in all three of the most recently settled cost reports. Hospital F did not reclassify as an SCH nor did it drop its rural status with the expiration of the MDH provision. In this case, Hospital F's MAC will automatically reinstate its MDH status retroactive to

April 1, 2015. The MAC will then notify Hospital F that it no longer qualifies for MDH status. The change in Hospital F's status (that is, disqualification from MDH status) will become effective 30 days after the date the MAC's written notification to Hospital F.

Notification to Provider

MACs will notify providers by a letter if the provider's MDH status is not reinstated seamlessly from April 1, 2015, because it falls within one of the two exceptions listed above or if the provider will lose its MDH status due to no longer meeting the criteria for MDH status, per the regulations at 42 CFR §412.108(b)(6).

Each MAC will add to each letter, information specific to that provider regarding how it is affected by the MDH program extension, that is, notifying the provider of its status under the extension of the MDH program. The status of each former MDH will either be:

1. MDH status not reinstated; additional action required by the provider in order to be classified as an MDH. Provider must request a cancellation of SCH status or submit a request for rural classification under 42 CFR §412.103. Provider will then have to reapply for MDH status in accordance with the regulations under 42 CFR §412.108(b).
2. MDH status reinstated and then subsequently cancelled due to the provider not continuing to meet the criteria for MDH classification under the requirements at 42 CFR §412.108(b)(5).

Hospital Specific (HSP) Rate Update for MDHs

For the payment of FY 2015 discharges occurring on or after April 1, 2015, the Hospital Specific (HSP) amount for MDHs in the PSF will continue to be entered in FY 2012 dollars. The PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and apply all update and other adjustment factors to the HSP amount for FY 2013 and beyond.

Additional Information

The official instruction, CR 9197, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3281CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under "How Does It Work" on the CMS website.